KANSAS HIV/STD SURVEILLANCE UPDATE

Kansas Department of Health and Environment
Bureau of Epidemiology and Disease Prevention

HIV NAME BASED REPORTING- THE FIRST YEAR

"We have entered an era in which HIV prevention needs are greater than ever before, and accurate data about where new HIV infections are occurring are critical"

All quotes in this article are from a pre-release statement by Helene Gayle, M.D., M.P.H. Director, National Center for HIV, STD, and TB Prevention Centers for Disease Control and Prevention, December 9, 1999 regarding the publication of "Guidelines for National HIV Surveillance" MMWR Dec. 10, 1999 / Vol. 48 / No. RR-13.

(See "HIV Named Based Reporting the First Year", page 3)

October 2000

Our Mission:
The HIV/STD section works to promote public health and enhance the quality of life for Kansas residents by the prevention, intervention, and treatment of HIV and other STDs. The mission will be accomplished through policy and resource development, clinical data collection and analysis, research, education, prevention programs, disease detection, and the provision of treatment and clinical care services.

SURVEILLANCE BENEFITS FROM BUREAU STAFFING CHANGES

Recent reorganization in the Bureau of Epidemiology and Disease Prevention (BEDP) combines the STD and HIV/AIDS sections into one HIV/STD section. As of June 12, 2000, the two sections were merged and restructured to formally integrate the functions and operations of programs that have worked in tandem for several years. The director of the HIV/STD section is Karl Milhon. Allen Mayer, formerly section director of the STD section, is now deputy director and directly responsible for the activities of the Surveillance Program and Field Operations of the combined section.

The Field Operations Supervisor and Chlamydia Coordinator is Derek Coppedge. In the field, Laurie Sheerin is a new Disease Intervention Specialist in STD region C (Wichita and SE Kansas). In the Surveillance Program Liatris Studer is the Surveillance Program Manager and the HIV/AIDS Epidemiologist is Anthony Merriweather.

What Is Surveillance?

Surveillance: "The ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. This information is used for planning, implementing and evaluating public health interventions."

In order to provide better service the Surveillance Program welcomes your suggestions regarding the contents of this Update. Please send them to the address at right c/o "Surveillance Program".

ACKNOWLEDGMENTS

A special thanks to the following persons who contributed to this update: Mindee Reece, Director, TB Section; Karl Milhon, Director, HIV/STD Section; Anthony Merriweather, HIV/AIDS Epidemiologist; Derek Coppedge, Chlamydia Coordinator; Scott Snyder, Teen Pregnancy Coordinator; Gail Hansen, Epidemiology Services; Barb VanCortlandt, Prevention Training; David Tritle, Ryan White Care Services.

Liatris Studer, Editor

HIV/STD Surveillance Update is a semi-annual publication of the Kansas Department of Health and Environment with funding assistance from the Centers for Disease Control and Prevention.

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The Kansas AIDS Ribbon was designed by the Kansas Capitol Area Chapter of the American Red Cross to raise hope and awareness in the state of Kansas and support the fight against HIV/AIDS.

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HIV NAME BASED REPORTING - THE FIRST YEAR

"In the wake of treatment advances, which have slowed the progression from HIV to AIDS for many individuals, data on AIDS cases alone are no longer reflective of new HIV infections." Helene Gayle, M.D., M.P.H.,Director, NCHSTP, CDC, Dec. 9, 1999.

The following pages contain data that have been collected, analyzed, and prepared to meet the needs of those committed to the prevention and treatment of viral and bacterial sexually transmitted disease.

In some aspects this newsletter is similar to updates and reports published in the past. However, with the inclusion of (name based reporting) HIV statistics in Kansas, the HIV/STD Section has reached a significant milestone in HIV surveillance.

"Data that clearly identify the leading edge of the epidemic are urgently needed."
Helene Gayle, MD, MPH

The process began In July, 1999, when statutory HIV name based reporting took effect requiring laboratories and physicians to report positive HIV tests.

In order to accommodate and facilitate HIV name based reporting, a decision was made to increase the surveillance staff to three persons enabling active pursuit and follow up on the diagnosis and reporting of HIV infections. Time and resources now exist to acquire valuable information from laboratories, blood banks, hospitals, medical service providers and vital records databases.

As part of the requirements of the statute, the surveillance program has reassessed confidentiality policies and procedures in the last year. This will be an ongoing process. Name based HIV reporting is successful where confidentiality of results is assured to those who are willing to be tested.

In the STD Program field staff absorbed an increased work load of partner notification activity. As HIV took priority, this came at the expense of other STD activities. The work of the field staff is vital to the section's stated mission (see page one for mission statement).

Name based HIV reporting was enabled by statute and regulation; particularly for reporting CD4+ and viral load levels and diagnosis criteria that allow for advances in testing technology. However, it was the cooperation of the hospitals, physicians and laboratories that made HIV surveillance successful in this first year. The surveillance program will work to maintain the partnership.

Continuum of Care-the Impact of Confidential HIV Reporting

"CDC's policy allows flexibility for states to choose the method of HIV reporting they deem most appropriate for their needs"
Helene Gayle, MD, MPH

Confidential HIV reporting allows insight into the impact that HIV disease is having on our society. With it the Health Department is able to target the resources it has to achieve its goals. The role of the Health Department relative to HIV is to first prevent the spread of disease. The Centers for Disease Control and Prevention estimates that approximately 40,000 people are newly infected with HIV each year. Activities and resulting services are designed to reduce that number in the future and improve public health.

This is done through an integrated group of federal and state

(Continued on page 4)

funded prevention interventions that consist of targeted behavioral science based HIV prevention activities and HIV counseling, testing and disease interventions that include partner counseling and referral services. All activities are based on training that incorporates HIV Prevention Counseling (HPC) tenets designed to identify individuals at risk for HIV and then to provide interactive counseling designed to reduce future risk behaviors.

A result of these activities, and indicative of the success of those activities, is that many individuals, as a first step, will begin to internalize their personal risk for contracting HIV and take the initiative to find out if they are HIV positive.

The next step is for the Health Department to refer positive individuals to care services and attempt to maximize the number of individuals that seek medical and other supportive care services. The dramatic impact of Highly Active Anti-Retroviral Therapy (HAART) on the health of individuals infected with HIV is a strong motivator for seeking care and furthering the prevention elements of the continuum of care.

The third step is to ensure that clinical care and medications are available for individuals that get tested and are found to be positive. Ryan White Care Services provide that safety net and also provides an incentive for at risk individuals to get tested.

The implementation of confidential HIV reporting now allows the Kansas HIV/STD program to know facts that it did not know with AIDS confidential reporting. An example is the fact that 20% (5 of 25) of all the women newly diagnosed and reported with HIV in Kansas in the first year were Hispanic. With AIDS only reporting, the data indicated that no Hispanic women were diagnosed (0 of 14). Since numbers are still small, no firm conclusions can be made. Eventually trends will become evident over time that will allow the HIV/STD Program and its community based partners to better serve the citizens of Kansas.

The data provided in this Surveillance Update can only be gathered in a confidential HIV reporting environment. The following is a summary of HIV/STD program activities and the resulting impact that confidential reporting is having on public health:

HIV Prevention Linked Testing (PLT)

- Publicly funded HIV Prevention targeting high risk behaviors interacted with approximately 15,000 individuals during the period, 30,000 interactions with the general population also occurred.
- 178 individuals were referred to HIV Counseling and Testing Sites from the federal and state funded HIV Prevention Projects.
- Of these individuals 1 was found to be positive for HIV.
- There were 871 documented referrals from various sources other than funded HIV Prevention Projects. The other positive case linked with a referral to testing was referred to testing by an infected partner.

Public HIV Counseling and Testing

- There were 12,727 tests performed in publicly funded HIV counseling and testing sites.
- The percentage confidentially tested was 87%, with 13% anonymously tested.
- There were 20 newly diagnosed cases as a result of this testing.
- Of the 20 cases, 11 have enrolled in Ryan White Care Services, 1 has other public insurance and 7 have no known care resources.

(Continued on page 5)

- Of the 99 newly diagnosed and reported cases of HIV, 26% were found through publicly funded counseling and testing activities with 3 found in Sexually Transmitted Disease Clinics, 20 found through counseling and testing sites and 3 found in correctional settings.

Partner Counseling and Referral Services (PCRS)

- Disease Intervention Specialists performed 103 partner counseling interviews. From this activity they were able to test 139 partners. 24 of these had previous testing but 115 (83%) had never been tested before.
- From the 139 tests, 11 (8%) newly diagnosed HIV cases were discovered as a result of this activity.
- Of the 11 newly diagnosed cases found as a result of PCRS, 6 (54%) were successfully referred to Ryan White Care Services, 3 (27%) had other medical insurance coverage and 2 (18%) presently do not have any coverage.

Referral to Care Services

- Of the 99 newly diagnosed and reported cases, 47 (47%) were enrolled in Ryan White Care Services including Ryan White Title I in Kansas City, Kansas, and Ryan White Title II and Ryan White Title III services at the Kansas University Medical Center in Wichita.
- 5 (5%) individuals are in Medicaid.
- 3 (3%) are enrolled in clinical trials for HIV medications.
- 10 (10%) have private insurance.
- 4 (4%) have no coverage.
- 30 (30%) are unknown as to their coverage.

The activities reflected in the data summarize the impact that the Health Department is having on HIV disease in Kansas. The complete first year progress report, "Reported HIV Infections in Kansas Between 07/01/1999 and 06/30/2000", is the source of these data and can be obtained from our office or from our website at: www.kdhe.state.ks.us/hiv-std.

HITS SURVEY

In collaboration with CDC, the surveillance program is conducting a limited, anonymous, HIV Testing Survey (HITS) among at-risk populations. Its purpose is to assess knowledge of state policies regarding testing and counseling; barriers for HIV testing; gaps in outreach, testing, prevention and treatment programs; and information on sex and drug using behaviors.

The study population consists of men who have sex with men, injection drug users, and high risk heterosexuals. The surveys are conducted at gay bars, street sites, and STD clinics located in Wichita and Kansas City. Each interview lasts about 30-45 minutes and the interviewee is given $20 for participating.

Dr. Farrell Webb of Kansas State University is the Primary Investigator for the survey. Surveying began July 7th and will be completed by December 31, 2000. 190 surveys have been completed as of August 21, 2000.

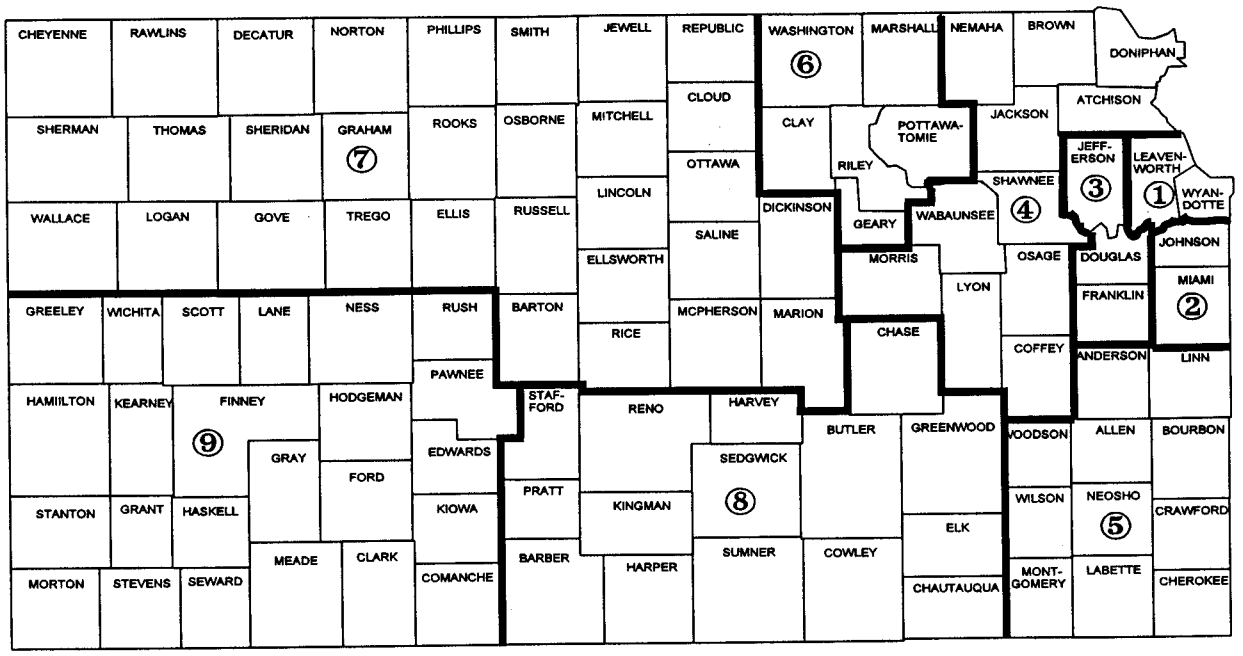
Teen Pregnancy Statistics

Statistics from the Bureau of Children, Youth & Families, KDHE, show decreasing teen pregnancy rates for all age groups in Kansas. Rates are stated as pregnancies per 1,000 women.

The rate for ages 10-14 was 1.3 in 1994, rose to 1.6 in 1995 and then fell to 1.1 in 1998, a decrease of 18.8%. The rate for ages 15-17 fell from 42.6 in 1993 to 33.8 in 1998, a decrease of 20.7%. The rate for ages 15-19 declined from 71.9 in 1994 to 62.0 in 1998, a decrease of 15.4%.

Nationally a new report, "Youth and HIV/AIDS 2000: A New American Agenda", states that HIV infection rates remain steady despite declining risky behavior. The report is available at: www.whitehouse.gov/ONAP.

Kansas Community Planning Regions

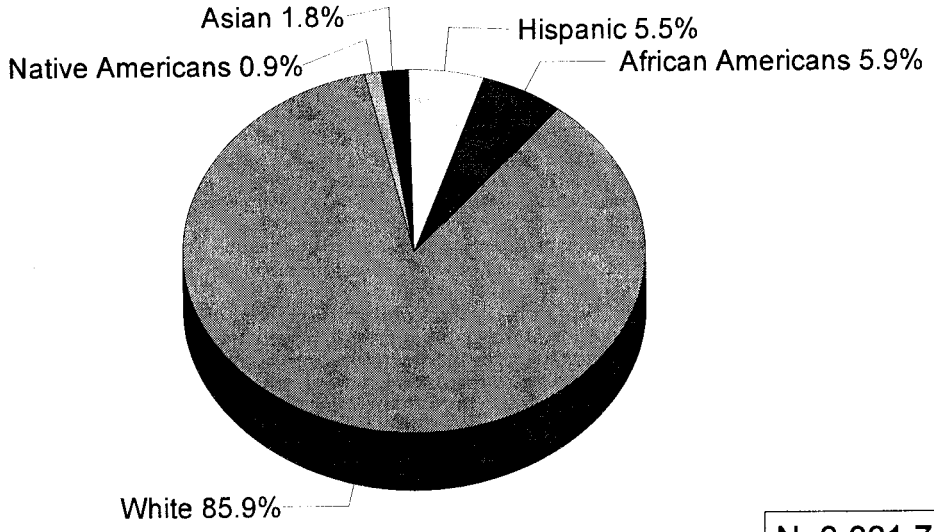


Kansas HIV/AIDS Cases by Community Planning Region
Reported 1981 - June 30, 2000

Region	Newly Diagnosed HIV Cases Reported[1] July 1999- June 2000	Newly Diagnosed AIDS Cases Reported[1] July 1999 - June 2000	Prevalent[2] HIV & AIDS Cases as of June 30, 2000	Cumulative[3] AIDS Cases as of June 30, 2000
1	20	16	246	449
2	8	14	170	389
3	0	2	49	100
4	15	10	101	225
9	3	2	23	106
6	6	5	27	76
7	3	3	37	72
8	39	43	428	783
9	5	1	30	61
Total	**99**	**96**	**1111**	**2261**

1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed still living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.

Kansas Population 1998 U.S. Census



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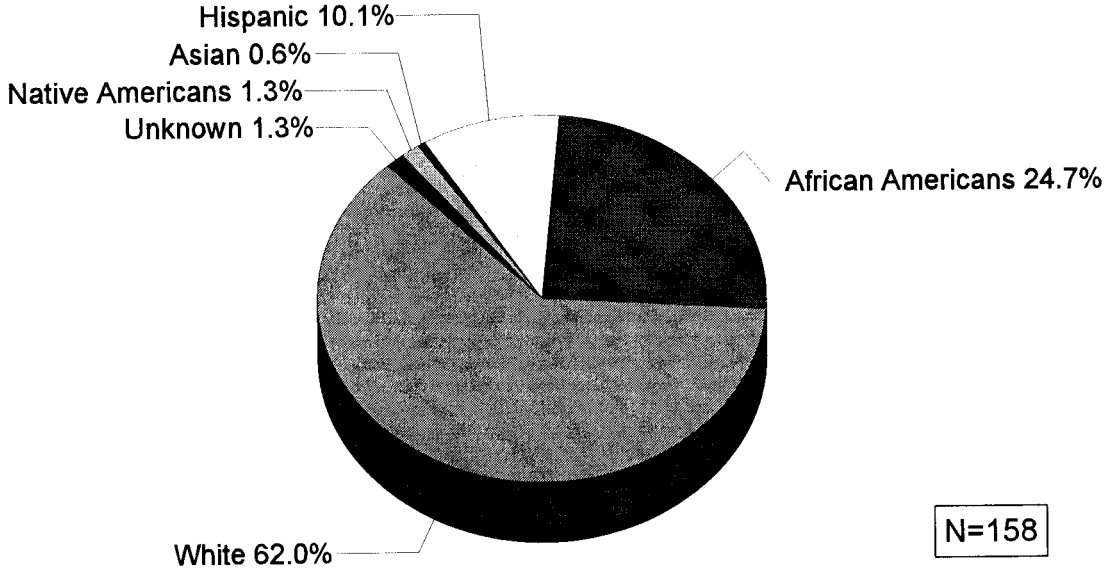
Reported Kansas AIDS Cases by Race/Ethnicity July 1999 - June 2000



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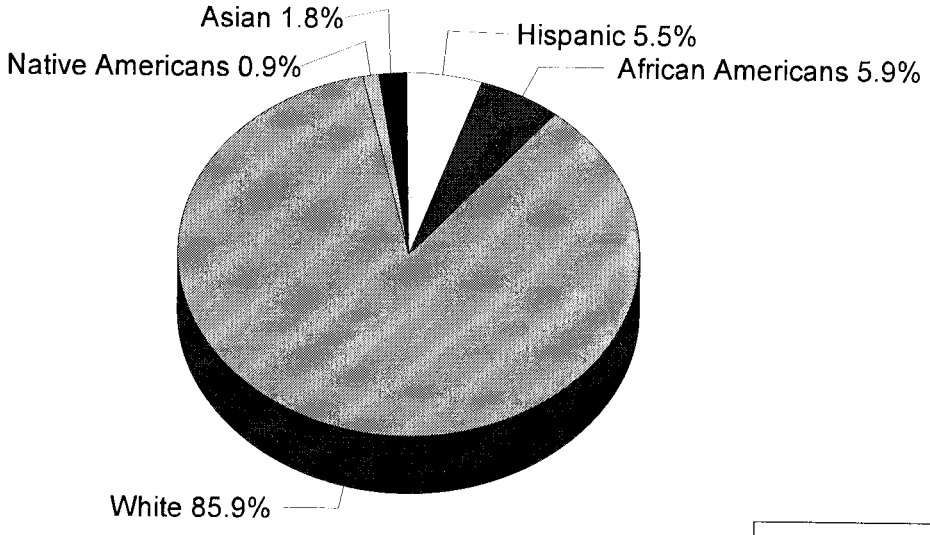
Kansas Population 1998 U.S. Census



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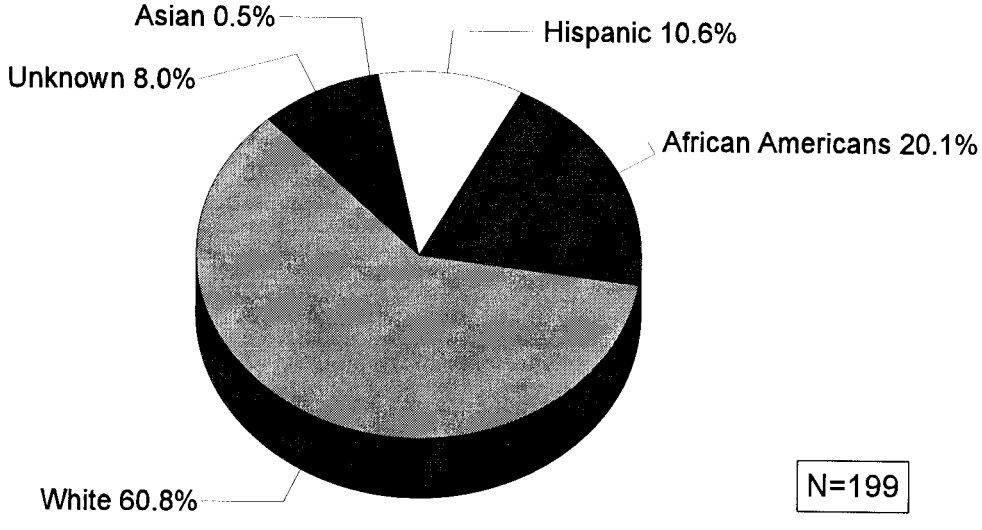
Reported Kansas HIV Cases by Race/Ethnicity July 1999 - June 2000



N=199

AIDS Reported[1] and Prevalent[2] Cases, Kansas

Race/Ethnicity	Reported AIDS Cases July 99 - Dec 99	Reported AIDS Cases Jan 00 - Jun 00	Reported AIDS Cases July 99 - Jun 00	Prevalent AIDS Cases as of Jun 00	Percent of Population
White	53 (66%)	46 (59%)	99 (63%)	636 (70%)	86%
African American	18 (23%)	20 (26%)	38 (24%)	185 (20%)	6%
Hispanic	7 (9%)	9 (12%)	16 (10%)	77 (8%)	5%
Asian	1 (1%)	0	1 (<1%)	4 (<1%)	2%
Native American	1 (1%)	1 (1%)	2 (1%)	11 (1%)	1%
Unknown	0	2 (3%)	2 (1%)	1 (<1%)	
Total	80 (100%)	78 (100%)	158 (100%)	915 (100%)	100%

Cumulative[3] HIV[4] AND AIDS Cases, United States and Kansas

U.S. Race/Ethnicity	U.S. Percent of U.S. Population	U.S. Cumulative HIV Cases as of December 99	U.S. Cumulative AIDS Cases as of December 99	KS. Cumulative HIV Cases as of Jun 00	KS. Cumulative AIDS Cases as of Jun 00	KS. Percent of KS. Population
White	(72%)	46,277 (38%)	318,354 (43%)	121 (61%)	1711 (76%)	86%
African American	(13%)	64,299 (52%)	272,881 (37%)	40 (19%)	384 (17%)	6%
Hispanic	(12%)	9,296 (8%)	133,703 (18%)	21 (10%)	133 (6%)	5%
Asian	(4%)	422 (<1%)	5,347 (0.7%)	1 (<1%)	9 (<1%)	2%
Native American	(1%)	742 (<1%)	2,132 (0.3%)	0	2 (<1%)	1%
Other /Unk		1,237 (1%)	957	16 (9%)	22 (1%)	0%
Total	(100%)	122,607 (100%)	733,374 (100%)	199 (100%)	2261 (100%)	100%

HIV Reported[1] and Prevalent[2] Cases, Kansas

Race/Ethnicity	Reported HIV Cases July 1, 99 - Dec. 31, 99	Reported HIV Cases Jan.1, 00 - June 30, 00	Reported HIV Cases July 1, 99 - June 30, 00	Prevalent HIV Cases as of Jun 00	Percent of Population
White	47 (59%)	74 (62%)	121 (61%)	119 (62%)	86%
African American	19 (24%)	21 (18%)	40 (19%)	40 (19%)	6%
Hispanic	10 (12%)	11 (9%)	21 (10%)	20 (9%)	5%
Asian	0	1 (1%)	1 (<1%)	1 (<1%)	2%
Native American	0	0	0	0	1%
Unknown	4 (5%)	12 (10%)	16 (9%)	16 (9%)	
Total	80 (100%)	119 (100%)	199 (100%)	196 (100%)	100%

Percentages may not add up to 100% due to rounding. All Kansas data are as of September 26, 2000.

1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.
4. From 34 areas with confidential HIV infection reporting.

AIDS Cases by exposure category, and sex reported[1] through June 2000, in Kansas

Adult/adolescent exposure category	MALE Prevalence[2] Total No. (%)	MALE Cumulative[3] Total No. (%)	FEMALE Prevalence Total No. (%)	FEMALE Cumulative Total No. (%)	Total Prevalence Total No. (%)	Total Cumulative Total No. (%)
Men who have sex with men	547 (69)	1464 (72)	-	-	547 (60)	1464 (65)
Injecting Drug Use	67 (8)	151 (7)	25 (22)	55 (26)	92 (10)	206 (9)
Men who have sex with men and inject drugs	85 (11)	205 (10)	-	-	85 (10)	205 (9)
Hemophilia/Coagulation disorder	9 (1)	40 (2)	1 (1)	1 (1)	10 (1)	41 (2)
Heterosexual contact (Total)	45 (6)	74 (4)	82 (71)	128 (60)	127 (14)	202 (9)
Sex with injecting drug user	*4*	*10*	*17*	*35*	*21*	*45*
Sex with other high risk partner	*1*	*3*	*14*	*28*	*15*	*31*
Sex w/HIV infected person risk not specified	*40*	*61*	*51*	*65*	*91*	*126*
Receipt of blood,blood components, or tissue	7 (1)	30 (1)	3 (3)	17 (8)	10 (1)	47 (2)
Risk not reported/other	31 (4)	67 (3)	5 (4)	12 (6)	35 (4)	73 (3)
Adult /adolescent Total	790 (100)	2030 (100)	116 (100)	213 (100)	906 (100)	2243 (100)
Pediatric (<13 years old)					9	18
		Total Cases			915	2261

HIV Cases by exposure category, and sex reported[1], July 1, 1999 - June 30, 2000, in Kansas

Adult/adolescent exposure category	MALE Prevalence Total No. (%)	MALE Cumulative Total No. (%)	FEMALE Prevalence Total No. (%)	FEMALE Cumulative Total No. (%)	Total Prevalence Total No. (%)	Total Cumulative Total No. (%)
Men who have sex with men	80 (53)	81 (52)	-	-	80 (42)	81 (41)
Injecting Drug Use	18 (11)	19 (12)	9 (23)	9 (23)	27 (13)	28 (14)
Men who have sex with men and inject drugs	13 (8)	13 (8)	-	-	13 (7)	13 (7)
Hemophilia/Coagulation disorder	0 (0)	0	0 (0)	0	0 (0)	0 (0)
Heterosexual contact	10 (6)	10 (6)	22 (56)	22 (50)	32 (15)	32 (15)
Sex with injecting drug user	*0*	*0*	*2*	*2*	*2*	*2*
Sex with other high risk partner	*0*	*0*	*2*	*2*	*2*	*2*
Sex w/HIV infected person risk not specified	*10*	*10*	*18*	*18*	*28*	*28*
Receipt of blood,blood components, or tissue	3 (2)	3 (2)	0	0	3 (2)	3 (2)
Risk not reported/other	29 (19)	30 (19)	8 (21)	8 (21)	37 (21)	38 1921)
Adult /adolescent Total	153 (100)	156 (100)	39 (100)	39 (100)	192 (100)	195 (100)
Pediatric (<13 years old)					4	4
		Total Cases			196	199

Percentages may not add up to 100% due to rounding. All Kansas data are as of September 26, 2000.

1. Reported or incident cases are the number of cases meeting CDC criteria for reporting in the given time frame.
2. Prevalent cases are those cases presumed living in Kansas on the indicated date.
3. Cumulative cases are the accumulated total of all reported cases.

STD STATISTICS FOR KANSAS
Jan.-July 2000

Chlamydia continues to be the most frequently reported STD in the state, with 88 of 105 counties reporting at least one case during the first half of 2000. Chlamydia is the leading cause of pelvic inflammatory disease, infertility and ectopic pregnancy. 3,023 cases of chlamydia were reported during the first half of 2000. This represents a 3% decrease compared to the same time period of 1999.

The number of reported gonorrhea cases are increasing. There were 1,310 cases reported which is a 3% increase compared to the same period last year. Studies show that gonorrhea, chlamydia and other non-ulcerative STDs can increase the risk of HIV transmission at least two to five fold. Non-ulcerative infections are more endemic in Kansas than ulcerative genital diseases.

Reported cases of early syphilis (less than one year's duration) have been declining since 1991. During the last six months, a total of 10 infections were reported, a 20% (2 case) decrease compared to the same time period in 1999.

Join the HIV/STD Staff for their presentation of "Exploring Partner Counseling and Referral Services and Viral STDs Bridging Theory and Practice". Coming to your area this fall. Hoxie 10/25; Beloit 10/26; Atchison 11/6; and Pittsburg 11/09.

HIV-TUBERCULOSIS CO-INFECTION

In 1944 the Federal Tuberculosis Program was created to provide guidance on TB control measures brought about by the advent of antibiotics. Drug therapies developed in the late 40's, early 50's, and 1971 brought a steady decline in both death and case rates for infection by *Mycobacterium tuberculosis* (TB). This downward trend continued until 1981 when the emergence of HIV created a significant population of immune system compromised, at-risk individuals. In 1987 extra-pulmonary TB disease became an AIDS defining infection for those who are HIV positive and in 1993 pulmonary TB was added.

It is possible to be infected with TB and not manifest active TB disease just as it is possible to be HIV positive without having symptoms of the active disease or an AIDS diagnosis. In Kansas, HIV infection, AIDS, and active TB are reportable diseases. The state case rate is approximately 6 per 100,000 population for AIDS (127 new cases in 1999); and, for active TB disease, approximately 3 per 100,000 (69 new cases in 1999). Since 1994 there have been 23 documented HIV/TB co-infections. Drug regimens are expensive, require high compliance, and drug resistant strains are a serious problem for both diseases. The susceptibility of HIV positive individuals to infection with *M. tuberculosis* and the complications of treating co-infections are matters of concern.

A recent study (MMWR, Aug.4, 2000) showed that few people exposed to active TB are assessed for HIV status and that 25% of those known to be HIV+ are not screened completely for TB. All HIV positive individuals should be screened for TB and those exposed to active TB should receive post exposure prophylactic treatment. The goal of the TB program is to assess at least 75% of all newly reported TB cases between the ages of 25-44 for possible HIV co-infection. Active TB disease is considered a presumptive risk category for HIV testing and all persons with active TB should be tested for HIV. Those having only a positive skin test should have some other risk factor indicated as a basis for HIV testing. HIV positivity or AIDS can also affect interpretation of TB screening tests. It is important that clients share a complete medical history with their care providers to help identify or rule out the potential for false negative results.

HIV/TB Treatment and Drug Interactions

Nucleoside Reverse Transcriptase Inhibitors and Protease Inhibitors used to treat HIV infections have substantive interactions with some of the Rifamycins utilized to treat *mycobacteria* infections. Treatment guidelines can be found in MMWR October 30, 1998, Vol. 47 No. RR-20.

Those wishing more information regarding the diagnosis or treatment of Tuberculosis can contact the TB Section, Bureau of Epidemiology and Disease Prevention, KDHE, at 785-296-5589.

KANSAS INFERTILITY PREVENTION PROJECT

The Kansas Infertility Prevention Project (KIPP) is a collaborative effort between Family Planning and STD Programs in the four states that make up Region VII (Kansas, Nebraska, Missouri, and Iowa) that focuses on the prevention and early treatment of chlamydial infections. We would like to supply relevant useful information to our screening sites concerning STDs other than chlamydia and gonorrhea. For more information contact Derek Coppedge at 785-296-6177

HEPATITIS

Viral hepatitis is a disorder in which viruses produce inflammation in liver cells. Viral hepatitis varies in severity from a self limiting condition and total recovery to a life-threatening or life-long disease and can be either acute or chronic. Acute hepatitis can begin suddenly or gradually, but it has a limited course and rarely lasts beyond one or two months. There is no chronic form of Hepatitis A, however chronic hepatitis B and C can persist for prolonged periods. All forms of Hepatitis are a reported disease in Kansas.

Who Gets Viral Hepatitis

Although there are at least 6 types of viral hepatitis (A, B, C, D, E, and G), hepatitis B and C are most often associated with risk factors for HIV infection. Hepatitis B is found in semen, blood, and saliva. It is spread through blood transfusions, contaminated needles, and sexual contact. Hepatitis B infects more than 200,000 people in the United States each year. Hepatitis C is spread through blood and contaminated needles and is the most common type of hepatitis in the United States. Hepatitis C can be spread through sexual contact though this is rarer than with Hepatitis B. Approximately 30% of the estimated 1 million persons infected with HIV are also co-infected with Hepatitis C.

Symptoms of Hepatitis

Symptoms of acute viral hepatitis may begin suddenly or develop gradually and may be so mild that patients mistake it for flu. Nearly all patients experience some fatigue and mild fever. Gastrointestinal (GI) problems are very common, including nausea and vomiting and a general feeling of discomfort in the abdomen or sharp pain in the area of the liver. This pain tends to increase during jerking movements, such as climbing stairs or riding on a bumpy road. GI problems can lead to loss of appetite, weight loss, and dehydration. After about two weeks, dark urine and jaundice (yellowing of the skin and eyes by bile pigments) develop in some, but not all, patients. Children tend not to develop jaundice nor do 75% of those infected with hepatitis C or 25-40% of those infected with hepatitis B .

Treating Viral Hepatitis

For mild cases of acute hepatitis, no drug therapy or other treatment is necessary or helpful. Hospitalization may be needed for people at high risk for complications, such as those with compromised immune systems. At the onset of hepatitis, periodic visits to the physician may be necessary.

The goals for treating all forms of chronic hepatitis are to relieve symptoms, prevent development of cirrhosis, reduce viral levels, and improve survival. Hepatitis C can be treated with interferon (INF) or a combination of INF and Ribavirin. Only about 15% of HIV/HCV co-infected patients achieve a sustained response to a standard course of INF monotherapy. Experience with Ribavirin is limited and drug-drug reactions with some medications used for treating HIV are possible.

Vaccines and Preventative Measures

Avoiding exposure and preventing transmission are the most important factors in preventing hepatitis. Most exposures are prevented by protected sexual contact, not sharing any blood or body fluids and using sterile syringes for intravenous drugs. HIV positive persons should be screened for hepatitis A, B, and C. Several vaccines are available for hepatitis A and B. Persons with chronic Hepatitis C are encouraged to be vaccinated if they have not been exposed to hepatitis A or B.

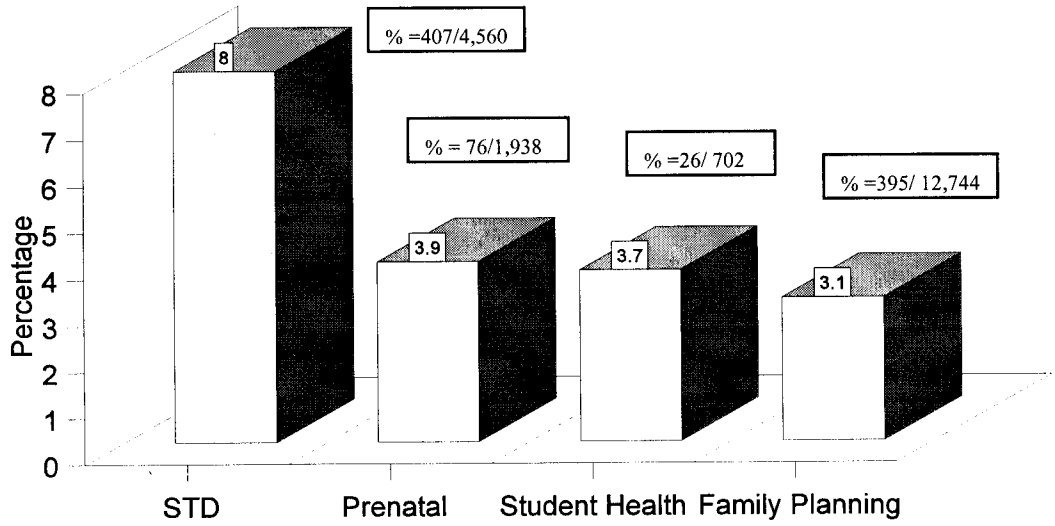
Further information regarding the prevention and treatment of Hepatitis can be found online at http://www.cdc.gov/ncidod/diseases/ hepatitis/index.

Kansas Infertility Prevention Project

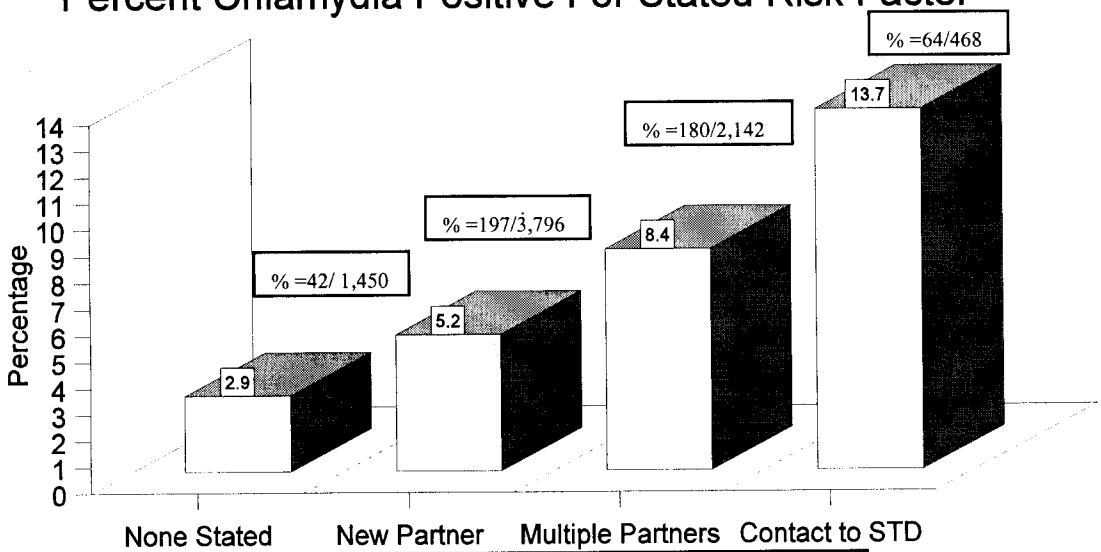
January 1,2000 through June 30, 2000

KIPP Sites Screened 19,944 Patients: 904(4.5%) Were Positive for Chlamydia by Gen Probe

Percent Chlamydia Positive By Clinic Type



Percent Chlamydia Positive For Stated Risk Factor



7,856 specimens indicated these risk factors. 483 were positive.

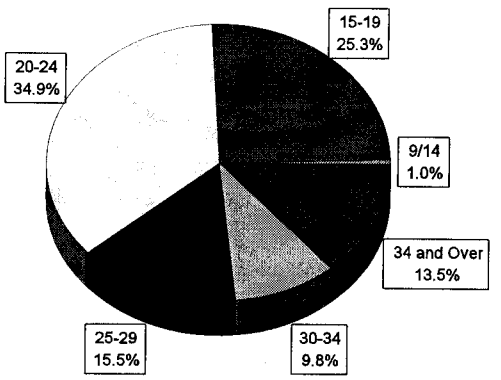
Positivity is highest in STD clinics and contacts to STDs.
This is consistent with screenings across CDC Family Planning Region VII which includes Kansas, Missouri, Iowa, and Nebraska.

CHLAMYDIA

Positive for Chlamydia by Gen Probe

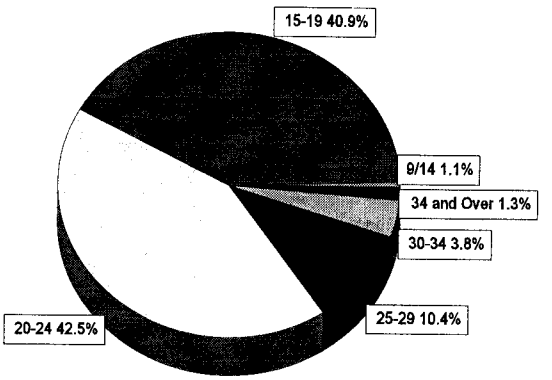
Total Tests By Age Group

n= 19,944



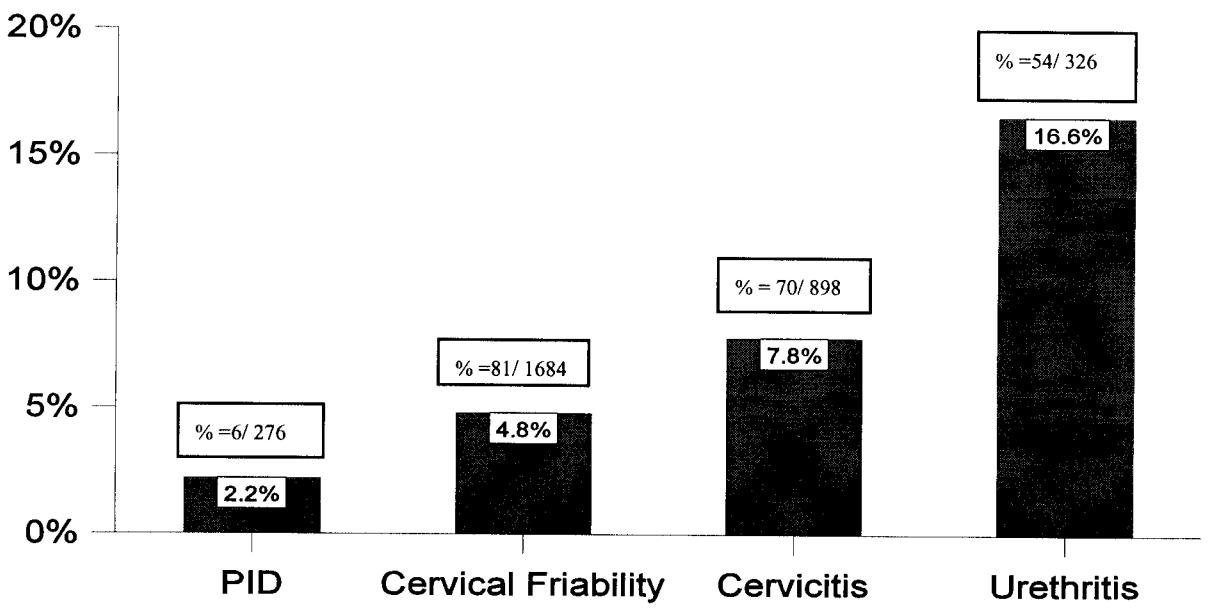
Percent Positives by Age Group

n = 904 positives



Chlamydia screenings are directed at the age groups most at risk in Kansas.

Chlamydia Test Results By Clinical Signs



3184 specimens indicated clinical signs. 211 were positive.

Urethritis is the best indicator of a chlamydial infection.

2001 HIV/STD PREVENTION TRAINING*

WHO SHOULD ATTEND?

HIV Counseling and Testing Site contractors must successfully complete Courses 1 & 2 prior to counseling clients. **Health Education/ Risk Reduction contractors and Ryan White Title II Case Managers** must successfully complete Courses 1, 2, 4 or 6, and 5 during their first year of employment. Contractors are encouraged to attend the culturally-specific Course 6 Fundamentals instead of Course 4 if they are serving specific populations of color. **All Contractors** must attend Course 7. **Other**: nurses, other health care providers, social workers, teachers, counselors, community educators and other interested persons working with individuals or groups of persons at risk of HIV/STD infection are invited to attend.
Registration fees may be waived for HIV-infected persons; contact KDHE at (785) 296-6174. **Continuing Education (CE) hours**: Nursing CE's ($20 per course); KADACA CE's ($15 per course).
For More Information: Contact KDHE at (785) 296-6174 for additional information. Brochures will be sent to all contractors approximately October, 2000.

1. HIV/STD Basic Training - $15 Topics include: current transmission/prevention issues, including human sexuality; drug use; statistics; attitudes and terminology related to risk behaviors; and basic psycho-social needs of infected persons. Includes American Red Cross HIV Starter Facts certification. **Sessions are Tuesdays from 8:00 a.m. to 5:00 p.m. January 9 in Topeka, May 8 in Wichita, September 11 in Kansas City, and November 6 in Salina.**

2. Behavior Change Counseling Strategies for HIV/STD Prevention - $15 *Must have satisfactorily completed Course 1.* Topics include: behavior change counseling concepts and skills; assisting clients in reducing risks of acquiring or transmitting HIV/STD's; helping clients improve perception of risk; negotiating realistic and incremental plans for clients to reduce risk; helping clients integrate test results emotionally, behaviorally, and socially; and referrals/ resources. **Sessions are Wednesdays 8:00 a.m. to 5:00 p.m. January 10 in Topeka, May 9 in Wichita, September 12 in Kansas City, and November 7 in Salina.**

3. STD Clinical Training - $15 Offered for health care providers who will be diagnosing STDs. *Must have satisfactorily completed Courses 1 & 2.* Topics include: presentation of patients; routine history and examination; guidelines for STD specimen collection; management, treatment, and follow-up of patients; and partner counseling. **Sessions are Thursdays from 8:00 a.m. to 5:00 p.m. on January 11 in Topeka, May 10 in Wichita, September 13 in Kansas City, and November 8 in Salina.**

4. Basic HIV Program: Fundamentals - $20 *Must have satisfactorily completed Course 1.* Includes American Red Cross Facts Practice and Instructor Candidate Training certification. Topics include: sharing facts about HIV/AIDS accurately, nonjudgmentally, and sensitively with people from diverse groups and communities; discussing facts related to sensitive issues like sex/sexuality and drugs/drug use; encouraging people to apply facts about HIV/AIDS to their own behavior; practicing using Modules 1 & 2 for working with community groups; assessing group needs; planning education sessions; facilitating interactive sessions; and making referrals to community resources. **Sessions are Tuesday 1:00 - 5:00 p.m., Wednesday 8:00 a.m. - 5:00 p.m., and Thursday 8:00 a.m. to 12:00 p.m.: February 13-15 in Topeka, June 12-14 in Wichita, and October 16-18 in Kansas City.**

5. Basic HIV Program: Prevention Skills - $20 *Satisfactory completion of Courses 1 and 4 are required before attending.* Topics include: facilitating skill-building activities related to HIV prevention behavior in a factually accurate, culturally sensitive, and nonjudgmental manner; understanding the content and format of activities in Modules 3 and 4; and identifying ways to use activities with persons age 17 and older. **Sessions are Wednesdays and Thursdays from 8:00 a.m. to 5:00 p.m. on April 11-12 in Topeka, August 8-9 in Wichita, and December 12-13 in Kansas City.**

6. Basic HIV Program: Fundamentals for Persons of Color - Free of Charge. *Must have satisfactorily completed Course 1.* At least 50% of course participants must be members of the population for which the course was designed. Participants need not be persons of color to attend, but community classes taught after certification must be co-facilitated with a trainer of color who is currently certified in the course being taught. **African American, Hispanic, and Native American** courses are available. Topics include: awareness of the culture and psycho-social issues involved in the African American, Hispanic, or Native American response to AIDS; basic factual information in a culturally sensitive manner; ways to incorporate cultural elements into HIV prevention; how to answer questions about HIV and AIDS in a culturally sensitive and age appropriate manner; and challenges people of color face in prevention. Courses are taught in a comfortable, safe, fun, and culturally sensitive environment with African American, Hispanic, or Native American instructors. African American and Hispanic courses **are 8:00 a.m. to 5:00 p.m. Tuesday, Wednesday, and Thursday. Native American courses are 1:00 p.m. to 5:00 p.m. Tuesday, 8:00 a.m. to 5:00 p.m. Wednesday, and 8:00 a.m. to mid-afternoon Thursday.**

African American
January 23-25, Junction City; September 25-27, Wichita

Hispanic
May 15-17, Great Bend; November 27-29, Wichita

Native American
March 20-22, Lawrence ; July 24-26, Wichita

7. 2001 UPDATE - Plans are to convene all Prevention and CARE contractors the afternoon of **Wednesday, April 25, and end after lunch on Thursday, April 26.** Plans include an evening information-sharing session and a screening of the movie "Shades of Gray." Meals and some travel and lodging assistance will be provided for KDHE contractors. More information will be sent to contractors as it is developed.

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***PLEASE NOTE:** All proposed 2001training information is subject to change. 9/00

2001 HIV/STD PREVENTION TRAINING SCHEDULE

(Call (785) 296-6174 for training brochures. Actual dates and locations to be confirmed by 11/00.)

Month	1. HIV/STD Basic Training Tuesday	2. Behavior Change Counseling Strategies for HIV/STD Prevention Wednesday	3. STD Clinical Training Thursday	4. Basic HIV Program: Fundamentals Tues-Thurs	5. Basic HIV Program: Prevention Skills Wed-Thurs	6. Basic HIV Program: Fundamentals for Persons of Color Tues-Thurs	7. 2001 Update Wed-Thurs
January	1/9/01 Topeka	1/10/01 Topeka	1/11/01 Topeka			African American 1/23-25/01 Junction City	
February				2/13-15/01 Topeka			
March						Native American 3/20-22/01 Lawrence	
April					4/11-12/01 Topeka		4/25-26/01 Wichita
May	5/8/01 Wichita	5/9/01 Wichita	5/10/01 Wichita			Hispanic 5/15-17/01 Great Bend	
June				6/12-14/01 Wichita			
July						Native American 7/24-26/01 Wichita	
August					8/8-9/01 Wichita		
September	9/11/01 Kansas City	9/12/01 Kansas City	9/13/01 Kansas City			African American 9/25-27/01 Wichita	
October				10/16-18/01 Kansas City			
November	11/6/01 Salina	11/07/01 Salina	11/8/01 Salina			Hispanic 11/27-29/01 Wichita	
December					12/12-13/01 Kansas City		

PLEASE NOTE: All proposed 2001 training information is currently subject to change. 9/00

Kansas Ryan White Title II C.A.R.E. Program

- Providing care services to those living with HIV and AIDS in the State of Kansas -

Ryan White Case Management has been an integral part of the care services program since its inception. Its purpose is to recognize and build upon the diverse approaches taken in case management throughout Kansas, while at the same time ensuring that persons living with HIV/AIDS in this state receive the level of case management services necessary to effectively respond to their needs. Through a collaborative effort, providers and policy makers came together to develop and refine the principles and standards of service. The outcome of this collaborative effort was "The Case Management Standards of Care." Since January 1, 2000, all Ryan White Title II Case Managers have worked under the guidance of "The Case Management Standards of Care" designed to live and change with the needs of clients and providers alike.

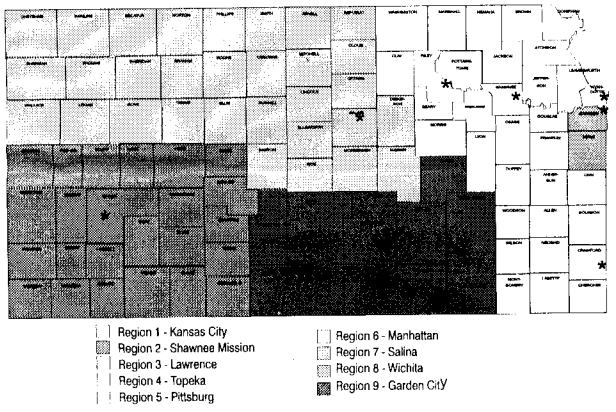
A STATEMENT of PRINCIPLES for CASE MANAGEMENT

Workgroups of people living with HIV/AIDS and Ryan White Title II Case Managers of Kansas prepared the seven statements of principles or "rights and responsibilities" for the consideration and guidance of providers of case management services. These statements serve as an outline of the kind of expectations held by people living with HIV/AIDS and therefore represent an invaluable resource to providers as they seek to center their services around the needs of their clients.

Noted below is contact information on the Ryan White Title II Case Management Sites throughout the state.

If you would like more information regarding Ryan White Title II Case Management or the Ryan White Title II C.A.R.E. Program, call the program offices at 785- 296-8891 or 316 687-9273.

HIV REGIONS in KANSAS



Ryan White Title II Case Management Sites:

Region 3: DCAP (Lawrence) Marilee Janssen 785-843-0040
Region 4: Sojourn (Topeka) Melba Sutton 785-233-5500
TAP (Topeka) Ludy Sapp-Keitzman 785-232-3100
Region 5: ARNOSK (Pittsburg) Deena Ulmer 800-738-AIDS
Region 6: Manhattan-Riley County Health Department (Manhattan) Stacey Broughman 785-776-4779
Region 7: Salina-Saline County Health Department (Salina) Marvena Wilson 785- 826-6600
Region 8: ConnectCare (Wichita) Lori Brewer, Teresa Romey, Randy Whisnant, Sue Lamar 316-265-9468
University of Kansas Medical Practice Assn (Wichita) Jan Danitschek, Angie Martinez 316-293-2617
Region 9: United Methodist Mexican-American Ministries (Garden City) Tina Hahn 316-275-1766

Kansas Ryan White Title II C.A.R.E. Program Statistics:

Effective April 1, 2000, the program has enrolled 51 new Kansans living with HIV and AIDS totaling 581 eligible clients enrolled in Title II Services. Of those eligible for Title II services, 328 have accessed care services since April 1, 2000. 277 have accessed the AIDS Drug Assistance Program (ADAP) since April 1, 2000. Listed below are the statistics of those clients currently eligible for C.A.R.E. Program services as of August 7, 2000:

Race:	109 (21%)	African-Amer.	Age:	17 (3.28%)	<26	Services Accessed:	277 (54%) ADAP
	38 (7.3%)	Hispanic		158 (30.51%)	26 - 35		66 (13%) Primary Care
	359 (69.3%)	Caucasian		233 (44.98%)	36 - 45		69 (13%) Dental Care
	3 (0.6%)	Asian-Pacific Islander		110 (21.23%)	>45		27 (5%) Mental Health
	7 (1.4%)	Amer. Indian/Native Amer.		Gender: 425 (82%) Male			2 (0.4%) Home Health
	2 (0.4%)	Other		93 (18%) Female			19 (4%) Insurance Cont.

Regional Breakdown:

36 (6.9%) Region 1	36 (6.9%) Region 2	24 (4.6%) Region 3	61 (11.8%) Region 4	24 (4.6%) Region 5
23 (4.4%) Region 6	32 (6.2%) Region 7	255 (49.2%) Region 8	27 (5.2%) Region 9	

Calendar:

Join the HIV/STD Staff for their presentation of "Exploring Partner Counseling and Referral Services (PCRS) and Viral STDs Bridging Theory and Practice". See below for dates and location.

KANSAS AIDS NETWORKING PROJECT, Proposed Future Meeting Dates: Tuesday, December 12, 2000, Wichita; Thursday, March 8, 2001, Topeka; Thursday, June 21, 2001, Hutchinson; Thursday, September 20, 2001, Lawrence; Thursday, December 6, 2001, Wichita.

October 25, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Hoxie
October 25-26, 2000: HIV Prevention Counseling Training, Lawrence
October 26, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Beloit
November 1, 2000: CPG Teleconference Meeting
November 6, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Atchison
November 9, 2000: "Exploring PCRS and Viral STDs Bridging Theory and Practice", Pittsburg
November 12-16, 2000: American Public Health Association Annual Meeting: Boston, Ma.
November 14-16, 2000: Basic HIV Program: "Fundamentals Training", Pittsburgh
December 1, 2000: World AIDS Day "AIDS: All Men-Make a Difference!"
December 12, 2000: KANP, Wichita
December 13-14, 2000: Basic HIV Program: "Prevention Skills", Wichita
January 10, 2001: CPG Meeting, Topeka